



<sup>\*</sup> Johns Hopkins Regional Partnership Initiative

## AIMS PRIMARY DRIVERS SECONDARY DRIVERS Early and frequent risk screening for complex needs JHM will improve care Transdisciplinary care planning through daily rounds coordination for: (a) > 8,000 M/M acute Pharmacist-driven medication management Acute care delivery care patients and 1,600 redesign M/M high risk community Preparation for self-care management through targeted patient/family education residents by the end of year 1, and (b) > 15,000 ED care coordination and use of protocols for common M/M acute care patients conditions and 3,000 M/M high risk community residents by Creation of after-hospital personal health plan the end of year 3. Primary provider handoff and early follow-up JHM will recruit, train, and Seamless deploy 25-30 new workers Moderate and high intense post-acute interventions transitions of care by the end of year 1 and (Transition Guides, Home Care, Skilled Nursing/Rehab 75-80 new workers by the Facilities) end of year 3 (along with many additional in-kind Patient Access Line (PAL) hires). Establish community partnerships JHM will reduce direct costs per inpatient by Predictive modeling to identify patients at high risk for 3-5% for the year postutilization Deployment of hospitalization, and will Care coordination teams with embedded case community care reduce total cost of care managers and behavioral specialists, and communityfor M/M high risk teams based community health workers, and volunteers community residents by 8-Frequent surveillance of patients' self-management, 10% per year and by 15adherence, barriers to care, and engagement 18% over 3 years. Integrated behavioral care based on risk